

EXHIBIT 20

Rebuttal Report of Daniel A. Henry, M.D. in Response to Export Report of Alan C. Whitehouse, M.D. - December 29, 2008

Premise

As an expert witness in the *IN re WR GRACE* bankruptcy proceedings, I have previously provided original statements and responses to various experts including the Libby claimants' expert. After reviewing the most recent expert report, I would like to address the issues pertinent to my field of expertise and my previous statements or responses.

Credentials and Experience

I have been a board certified radiologist for nearly 34 years and a dedicated chest radiologist for 32 years. I am chief of section of Thoracic Imaging at a large tertiary care medical center and have an academic practice dedicated solely to the interpretation of images of the chest. I interpret both conventional chest radiographs or chest x-rays and computed tomography of the chest or chest CT's, both standard CT's and high-resolution chest CT (HRCT). I also interpret chest CTA's or CT angiograms for pulmonary embolism, chest trauma, and aortic diseases which all include high-resolution images of the adjacent lungs. Newer CT scanners have made it possible to routinely obtain very thin slices of the lung processed with high spatial algorithms similar to HRCT on every chest CT's which is the norm in our practice. I have been interpreting chest CT's since the mid'80's and HRCT for 15 years. By conservative estimate, I have interpreted thousands of chest CT's and hundreds of thousands of chest radiographs over my 32 year career as a chest radiologist. I have interpreted close to two thousand chest CT's for pulmonary embolism alone, each including HRCT studies of the lungs. I am a long time faculty member of the Department of Radiology at the Medical College of Virginia Hospitals and Clinics and the Virginia Commonwealth University School of Medicine. I instruct and supervise physician residents in radiology training each day in the interpretation of images of the thorax. I also instruct fellows in pulmonary medicine in basic chest imaging.

I have the opportunity to view chest images on a very broad spectrum of pulmonary, mediastinal, and cardiovascular pathology. As a tertiary referral center we see patients with quite varied disease states and many in the advanced stages of their illnesses. We collaborate daily with a large group of pulmonologists on a varied group of patients both through their consultations as well as their own patients. I see images of patients with collagen vascular diseases, complex infections, solid and hematological malignancies, various organ transplants including lung, interstitial pneumonias, immunocompromised patients, various exposures including occupational exposures, drug reactions, vasculitis, smoking related disorders, airway diseases, and pulmonary hypertension to name a few.

My interest in occupational lung disease was initiated more than 25 years ago by a pulmonologist who invited my assistance in the radiographic evaluation of miners being considered for worker compensation by the Commonwealth of Virginia. We became B-readers together at the same time, more than 20 years ago. I have been a National Institutes of Occupational Safety and Health (NIOSH) certified B-reader continuously for nearly 24 years having been recertified multiple times. Since 1990, I have been a faculty member and lecturer of the American College of Radiology (ACR) Committee on Pneumoconioses and am currently chair of that committee. I am also a fellow of the American College of Radiology. The ACR and the Pneumoconioses Committee periodically hold educational symposia in collaboration with NIOSH for those wishing to become or be recertified as a B-reader. I am the Program Chair of the next Symposium that will be held this month. I also continue as a consultant to the Workers Compensation Commission of the Commonwealth of Virginia in collaboration with two other B-readers, both pulmonologists, interpreting chest x-rays of potential claimants.

In March of 2008, I was invited by NIOSH to speak at a workshop they sponsored on the transition from film to digital media for chest imaging for pneumoconioses. I have also interpreted comparison chest images for NIOSH on both film and digital workstations as part of their ongoing project of transition to digital radiography. I have also read chest x-rays for the NIOSH sponsored B-reader educational programs and their coal workers surveillance program. I recently declined an invitation to participate in an Agency for Toxic Substances and Disease Registry (ASTDR) sponsored program to interpret chest x-rays and CT scans on Libby subjects due to conflicts with preparation for the upcoming ACR Pneumoconioses Symposium and my academic responsibilities.

At my institution, the pulmonologists and radiologists work collaboratively for the benefit of the patient. We support one another's teaching programs and research endeavors. We don't have a confrontational or combative relationship. I have worked with the same group of pulmonologists for over 25 years and trained them, in some cases, in radiology when they were pulmonary fellows. As thoracic imaging has become more complex and sophisticated, the pulmonologists continue to seek us out for assistance. Our collaborative efforts and the professional relationships I have enjoyed over the past many years are highlights of my academic career.

Goals

On April 26, 2005, Dr. James Crapo appeared before the Senate Judiciary Committee to read a prepared statement regarding the medical criteria for S. 852, The Fairness in Asbestos Injury Resolution Act of 2005 (1). Dr Crapo is a Professor of Medicine and Pulmonary Diseases at the National Jewish Medical and Research Center in Denver that is the nation's top ranked hospital in pulmonary disease. He is also past president of the American Thoracic Society. S.852 or the " Fair Act of 2005" proposed the development of a national trust to address the myriads of claims for asbestos related disorders.

Dr. Crapo recognized the various challenges and concerns making several recommendations including a rigorous quality assurance program to ensure the reliability of the medical data including an independent B reading of the chest x-rays for all claims. He proposed a comprehensive audit procedure to review all claims to strengthen the function of the proposed trust. Similar to the process of developing a national trust for asbestos claims and the concerns raised by Dr. Crapo, W.R. Grace faces a like challenge of funding a trust and establishing valid scientific and medical standards for the review of asbestos claims so that individuals with significant injury and impairment from exposure receive appropriate compensation while compensation of invalid claims is minimized or eliminated. I concur with Dr. Crapo and strongly encourage the adoption of an independent B-reading of the chest x-rays for all relevant claims to promote standardization and reliability of the medical imaging data.

2004 ATS Guidelines

Dr. Whitehouse states the following: 'For the diagnosis of asbestos related disease, we use the criteria of the American Thoracic Society (2004) Official Statement, "Diagnosis and Initial Management of Nonmalignant Diseases Related to Asbestos".' (p 5)

In 2004, the American Thoracic Society (ATS) published a document that has become the authoritative reference specifically for the evaluation of individuals with asbestos related disorders. The document, referred to as the American Thoracic Society 2004 Official Statement (ATS'04 Statement), is entitled "Diagnosis and Initial Management of Nonmalignant Diseases Related to Asbestos" (2). While I have reservations about a few areas of this paper, I cannot deny its comprehensive scope, detail, and well-referenced discussions as an authoritative consensus view of the current state of knowledge with respect to the diagnosis of nonmalignant disease related to asbestos. It offers several guidelines for the diagnosis and care of patients with asbestos related disorders. It replaces a previous document of a similar type published in 1986. The first page of this document introduces a section entitled "Diagnostic Criteria and Guidelines for Documenting Them". In this section are criteria for the diagnosis of nonmalignant asbestos-related disease including "evidence of structural pathology consistent with asbestos-related disease as documented by imaging or histology" as one of three diagnostic criteria. The other criteria are evidence of causation by asbestos and exclusion of alternative plausible causes. Thus, medical imaging data is critical since, in the absence of tissue biopsy, it is the only pathway to meeting the first criteria for diagnosis. The document further states that demonstration of functional impairment is not required for the diagnosis but should be documented for complete evaluation.

Validity of the B-reading process and the ILO Classification System

Dr. Whitehouse states the following: "The ILO system is not used in clinical practice in the Northwest United States.....The ILO (2000) scoring system for chest x-rays and the B-reader certification is for research purposes." (p61)

I embraced the International Labor Office (ILO) system of film classification for pneumoconiosis and the B-reader process many years ago because it was and is the currency of the radiographic evaluation of those exposed to occupational dusts. The ILO system is deeply entrenched in the dust surveillance activities of the National Institutes of Occupational Safety and Health (NIOSH) that orchestrates the B-reader process and certifies B-readers as competent in the ILO system. The ILO system is used worldwide for the radiographic evaluation of dust diseases. It is used both for clinical and research purposes as mandated in the ILO guidelines and is well established in the medico legal process of worker compensation and has been so since at least the late 60's by federal regulation. The ILO system is not an archaic, irrelevant device with very limited application as suggested by Dr. Whitehouse. It continues to be used for clinical purposes and is strongly supported in the world's medical literature and in countless research papers. After all, the practice of medicine is based on peer-reviewed research and its transition to practice as evidence based medicine. This is the hallmark of contemporary medicine.

The practice of medicine and medical decision-making are made more transparent by staging, measurement, and classification systems that are part and parcel of the everyday practice of medicine regardless of subspecialty. These systems are guides to therapy and treatment. We stage lung and various other cancers, measure lymph nodes, calibrate coronary artery stenosis, classify stages of heart failure and breast disease, and treat diseases based upon these various measurements. These systems provide a common denominator for understanding and communication among providers, validate decision-making, and facilitate care according to accepted norms of practice. The ILO system is another measurement tool to bring some sense of organization and understanding to a complex area of healthcare. It has even been extrapolated to non-occupational thorax diseases. To disregard it and its well established role in the evaluation of patients exposed to occupational dusts makes the process more opaque and ignores the rich legacy of literature in which the ILO system is utilized. To limit or exclude the application of the B-reader process and the ILO classification system would remove the only standardized and proven interpretation system available for this application. This would effectively compromise the reliability of the medical imaging data.

The ATS'04 Statement acknowledges the utility of the ILO classification system in the pursuit of objective findings for the diagnosis and clinical evaluation of non-malignant disease related to asbestos: "This system (ILO), which is the basis of the 'B-reader' qualification for designating persons as competent in classifying pneumoconiosis films, was developed for grading the radiographic severity of pneumoconiosis in epidemiologic studies but has been applied to clinical settings to maintain consistency in classifying films." (p 696)

The ILO classification system is commonly used for the surveillance of workers exposed to occupational dusts. Two recent Morbidity Mortality Weekly Report (MMWR), authored by CDC, detail its role in the examination of nearly 1000 miners in Kentucky

and Virginia and the detection of advanced pneumoconiosis (2,3). The report also lists the examination protocol for repeated radiographic examination at regular intervals during employment for the prevention of pneumoconiosis. In my opinion, this activity by U.S. Public Health physicians screening and removing workers from dangerous exposures qualifies as patient care. This activity has been ongoing for decades.

Dr. Whitehouse states the following: "There is no B Reader in Montana." (p61)

I know very experienced B-readers at National Jewish in Denver, the University of Washington, and the University of Nebraska. I'm sure they would be available to consult if requested. Published articles detailing large B-reader projects on Libby subjects were completed without difficulty. The ASTDR is currently performing a large B-reader project on Libby subjects and is making the films available to B-readers at convenient locations around the country. Any licensed physician is eligible to take the B-reader certification examination regardless of their state of residence. I do not understand how the paucity of B-readers in any geographic area is a springboard to the conclusion that the B-reader program is mainly for research and not appropriate for clinical practice. Perhaps that conclusion is understandable if you do not use the ILO system or are not familiar with it. Geography should not be a problem.

Standardization of Medical Imaging Data

Over the past many years, several scientific papers regarding the asbestos-contaminated vermiculite in the Libby, Montana community have been published (5-9). At least four papers have specifically addressed chest radiographic findings of various populations in the Libby area and in a fifth paper describing the distant exposure of workers to Libby mined products, the radiographic findings were integral to the conclusions. These papers span a period from 1984 through 2008 and describe as few as a dozen participants to as many as over 6,000. They chronicle the various projects of federal and state agencies as well as university-based investigators. While their intended goals or conclusions may vary, they all had at least one thing in common. Each one of these papers and projects used a B-reader interpretation and the ILO classification system to record and standardize the chest x-ray imaging data. This standardization allows comparison of one report to another as well as to other reports with similar or dissimilar exposures. They promote better understanding due to the widespread acceptance and utility of the ILO system in the medical and scientific communities in the US and around the world, and support valid conclusions and longitudinal decision-making. The clearly stated and standardized protocols for interpretation and ILO classification allow others to duplicate the work. Each report builds upon its predecessor creating a foundation for future study and reporting. They have created a scientific precedent for this population. If each of these papers had employed different or non-standardized interpretive methods, comparison would be much more difficult if at all possible and the utility of the data would be isolated and minimized.

In 2004, Dr Whitehouse authored a peer reviewed paper entitled “Asbestos-related pleural disease due to tremolite associated with progressive loss of lung function: serial observations in 123 miners, family members, and residents of Libby, Montana”(10). Chest x-ray or CT imaging was central to this paper since the presence of pleural disease had to be established by imaging tools. Considering Dr. Whitehouse’s disdain for the B-reader process and the ILO classification system, I took special note of how the imaging data was organized and recorded. In the “Materials and Methods” section of the paper, the following appears:

“The initial postero-anterior chest x-ray was graded for extent of pleural changes by the principal investigator and also by a board certified radiologist (Dr. Teel). The extent of pleural disease was graded as follows. The percentage of the lateral chest wall involved with pleural changes was measured and the average of both sides was calculated.”

The “Materials and Methods” section of most scientific papers is devoted to the protocols, processes, and scientific methods used by the investigator(s) to acquire the results which form the basis for the conclusions reached. The “Results” section usually follows and is somewhat of a mirror image of the “Material and Methods” section listing the tabulations, outcomes, etc from the various methods previously mentioned and employed. The portion of the “Results” section of the Dr. Whitehouse’s paper that deals with the imaging data includes the following:

“The majority had pleural changes only, consisting of either pleural plaques or diffuse pleural thickening. Because only about half the patients had high resolution computed tomography (HRCT) scans, it was not possible to differentiate this further with any certainty due to the variations between the plain chest film and the HRCT. A total of 67 of 123 (55%) had no evidence on chest x-ray or HRCT of interstitial changes. The remaining patients (56) had minimal radiographic evidence of irregular interstitial changes involving the bases at profusion category 0/1 or 1/0. Of 123 films reviewed, 4 subject films were felt to be normal or equivocal. Of these, all subsequently developed overt pleural changes within a few years and 3 of 4 had pleural changes consistent with asbestos exposure on HRCT..... Extent of pleural changes as measured as described on the chest x-ray was evaluated in relation to the loss of lung function. There was no statistical correlation between the extent of pleural changes measured on the chest x-ray and the loss of lung function....”

There is no mention in the “Results” section or anywhere else of the percentage measurements of pleural involvement or calculations promised in the “ Methods” section. All that is listed are “changes”. The protocol for the HRCT is never mentioned nor was the use of HRCT even mentioned in the “Methods” section. HRCT simply appears in the “Results” section. Who interpreted the HRCT’s and what criteria were employed to determine the presence of “interstitial changes”? Interestingly, 0/1 and 1/0 are small opacity profusion grades pirated from the ILO classification system that is not used in the